and 24 account for 26 percent of new HIV infections each year, with nearly 60 percent unaware that they are infected.

The Advocates for Youth organization in conjunction with 11 other founding partners are supporting young people in the fight against HIV and AIDS. This national day marks an important step toward recognizing the key role that future generations play in becoming leaders in disease prevention and education.

Three years ago, the White House unveiled the National HIV/AIDS Strategy, our country's first-ever comprehensive plan with measurable goals to be achieved by 2015. This plan calls for a renewed commitment and increased public attention to meet three goals: reduce the number of people who become infected with HIV; increase access to care and improve health outcomes for people living with HIV; and reduce HIV-related health disparities. In outlining these goals, President Obama challenged everyone to partner in supporting the implementation of the innovative strategy ''that provides a clear direction for moving forward together.''

North Carolina ranks in the top ten states for rates of new HIV infection. This alarming statistic is one of the reasons why medical professionals such as Dr. Michelle Collins-Ogle, of Northern Outreach Clinic in Henderson, North Carolina are so passionate about offering illness education, prevention, testing, and medical intervention. Even with few resources, Dr. Ogle, the clinic's director, fights not just the disease but the perceived stigma of the disease as well.

As a former civil rights attorney I applaud the efforts of organizations who are advocating for the rights of people living with HIV and AIDS. Organizations such as the North Carolina AIDS Action Network, who mobilized support to persuade the AIDS Drug Assistance Program to reopen new enrollments for low-income people needing access to life-saving HIV medication. I want to also recognize Duke University's AIDS Legal Project, a pro bono program that trains law school students to serve the unmet need of providing legal counsel to highly stigmatized, low-income HIV-infected clients.

Combating HIV and AIDS, as with any other illness plaguing this country, requires a partnership for success. That partnership must include action on behalf of our governing bodies, healthcare providers, and individual citizens to keep these issues at the forefront of the minds of all Americans.

Mr. Speaker, I ask my colleagues to join me in recognizing April 10th as National Youth HIV & Awareness Day as we salute the efforts of young people nationwide who are tirelessly and effectively working toward achieving the goal of an AIDS-free generation.

HONORING NILS HAUGEN

HON. SAM GRAVES

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Thursday, April 11, 2013

Mr. GRAVES of Missouri. Mr. Speaker, I proudly pause to recognize Nils Haugen. Nils is a very special young man who has exemplified the finest qualities of citizenship and leadership by taking an active part in the Boy Scouts of America, Troop 374, and earning the most prestigious award of Eagle Scout.

Nils has been very active with his troop, participating in many scout activities. Over the many years Nils has been involved with scouting, he has not only earned numerous merit badges, but also the respect of his family, peers, and community. Most notably, Nils has contributed to his community through his Eagle Scout project. Nils built two picnic tables and two benches at the Northland Therapeutic Riding Center in Holt, Missouri, which provides equine-based therapy for people with special needs.

Mr. Speaker, I proudly ask you to join me in commending Nils Haugen for his accomplishments with the Boy Scouts of America and for his efforts put forth in achieving the highest distinction of Eagle Scout.

IMPROVED HEALTH CARE AT LOWER COST ACT OF 2013

HON. JIM McDERMOTT

OF WASHINGTON

IN THE HOUSE OF REPRESENTATIVES

Thursday, April 11, 2013

Mr. McDERMOTT. Mr. Speaker, it is widely accepted, on both sides of the aisle in both the House and Senate, that health care costs are the single major driver of our deficit and that we need better quality health care at lower costs—for our citizens and for our economy. When it comes to implementing carefully crafted gainsharing programs, existing law is in the way. To meet the three goals of (1) decreasing costs, (2) improving quality, and (3) not compromising access to health care services, the ''Improved Health Care at Lower Cost Act of 2013'' (the ''Act'') will require the OIG and CMS to issue regulations that define standards for gainsharing and similar arrangements that will be protected under the anti-fraud laws. The requirements that federal regulators set should include a primary emphasis on quality. OIG has vast experience in approving shared savings programs where the shared savings payment to physicians by the hospital was conditioned upon meeting certain quality metrics. The idea that shared savings payments should take quality into account seems obvious to me; no one should be permitted to share in savings that the hospital accrues without demonstrating that quality either improved, or at a minimum, was not adversely impacted by such arrangements. I am assuming that regulators will draw upon their vast experience with these programs and put in place sufficient protections to guard against fraud, waste, and abuse. Such protections may include requirements around quality; comparisons against historical data; a ceiling on savings that will inure to any given physician; and a requirement that arrangements be reduced to writing to ensure that it easier to identify arrangements that do not comply with the requirements that CMS and OIG set through rulemaking.

The Act will allow hospitals and physicians to better align incentives in order to decrease health care costs through allowing certain ''gainsharing'' arrangements. The term ''gainsharing'' refers to arrangements where hospitals share with physicians any reduction in the hospital's costs for patient care that the hospital gets as a result of the efforts of the physician. Currently, gainsharing arrangements are prohibited under several anti-fraud laws. First, the federal Civil Monetary Penalty statute prevents hospitals and physicians from engaging in ''gainsharing'' arrangements. Second, the Office of the Inspector General for the Department of Health and Human Services (''OIG'') has indicated that gainsharing arrangements may implicate the federal Anti-Kickback law. Finally, gainsharing arrangements may be prohibited by the Physician Self-Referral law. Because of the potential legal implications, hospitals and physicians have been reluctant to participate in gainsharing arrangements for fear of prosecution under all of these laws or even under the False Claims Act.

Notwithstanding existing law, the government has acknowledged that there is potential benefit associated with gainsharing arrangements. In its 1999 guidance, the OIG said:

> [t]he OIG recognizes that hospitals have a legitimate interest in enlisting physicians in their efforts to eliminate unnecessary costs. Savings that do not affect the quality of patient care may be generated in many ways[.] Achieving these savings may require substantial effort on the part of the participating physicians. Obviously, a reduction in health care costs that does not adversely affect the quality of the health care provided to patients is in the best interest of the nation's health care system [emphasis supplied].

Then, in 2005, MedPAC issued a recommendation in its Report to Congress that hospitals and physicians be permitted to engage in gainsharing arrangements. In this report, MedPAC stated that:

> [t]he Commission believes that gainsharing arrangements have the potential to improve patient care and reduce hospital costs as long as safeguards are in place to minimize the undesirable incentives. . . Due to the potential for gainsharing arrangements to encourage physician and hospital cooperation to lower costs and improve care, the Congress should provide the Secretary with the authority to allow and regulate these arrangements. The Secretary should develop rules that allow gainsharing arrangements as long as safeguards exist to ensure that cost-saving measures do not reduce quality or inappropriately influence physician referrals [emphasis supplied].

Finally, in 2008, the Centers for Medicare and Medicaid Services (''CMS'') issued a proposed rule that would have created an exception under the Physician Self-Referral law to protect certain ''shared savings and incentive payment programs.'' In the preamble to the proposed rule, CMS stated the following:

> [s]hared savings programs have been recognized by stakeholders as an effective means of controlling costs, improving efficiency, and promoting quality in the delivery of health care services. Government stakeholders have recognized similar potential benefits when shared savings programs are properly structured to ensure compliance with Federal health care program requirements. Empirical evidence suggests that the goal of patient care quality maintenance or improvement can be achieved through a properly-designed shared savings program.

The rule was never finalized. However, based upon the assertions of OIG, MedPAC, and CMS, the evidence seems clear and convincing: properly structured gainsharing programs show substantial potential in reducing